

An Independent Assessment
of Minnesota's Medicaid Home and
Community Based Services Waiver Program

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EXECUTIVE SUMMARY

This Executive Summary highlights key findings of an independent assessment of Minnesota's Medicaid Home and Community Based Services (HCBS) program for persons with mental retardation and related conditions (MR/RC). HCBS programs allow states to finance under Medicaid certain "non-institutional" services for Medicaid-eligible individuals who would without those services be at risk of remaining or being placed in a Medicaid certified institution (i.e., an Intermediate Care Facility for the Mentally Retarded [ICF-MR] or a nursing home). In requesting approval to provide HCBS, states must make assurances that total Medicaid expenditures under an HCBS waiver will be no more than total Medicaid expenditures would have been in the absence of an HCBS program. States must also make other assurances regarding access to and quality of the services they provide. An independent assessment of a state's HCBS program, providing evidence of satisfactory compliance with federal HCBS regulations, is required prior to the approval of a state's request every 5 years for a renewal of their authority to provide Medicaid Home and Community Based Services. The purpose of this assessment was to evaluate the overall success of Minnesota's HCBS program in meeting the required federal standards, as well as a number of specific state goals. The assessment is organized into three areas: 1) access to services, 2) cost-effectiveness, and 3) quality of services.

Data Collection

Data collection for this assessment included a sample of 129 HCBS recipients living in 18 counties of Minnesota and people important in their lives, interviews with people playing key roles in the delivery of HCBS, and extensive use of state databases. Data collection, based on the HCBS recipient sample, involved structured interview and/or questionnaire responses with 129 direct care providers (paid staff and foster family or natural family members), the 60 case managers of 118 of the sampled individuals, 82 family members, and 54 HCBS recipients themselves. Data gathered included information on the functional skills, activities, services received, needs, relationships, choices and preferences, and other aspects of daily life of the HCBS recipient, the quality of and satisfaction with services of recipients, their families and case managers, and recommendation for improving services from those involved. In addition to the structured data collection, over two dozen other interviews about program implementation and quality were conducted with a wide range of individuals playing key roles in the delivery of HCBS, including county officials from almost all sampled counties, present and former state Medicaid and Developmental Disabilities officials, directors of HCBS provider agencies, and direct services providers. Finally, extensive use was also made of the state's existing data bases, especially those containing screening data on HCBS and other Medicaid recipients' characteristics and needs and those containing HCBS expenditures for each individual recipient.

General Program Trends

Minnesota's HCBS program is one of the largest in the U.S. and has been one of the most rapidly growing.

- In FY 1985, Minnesota's first year of providing HCBS, 278 individuals with MR/RC received waiver services; in FY 1987, 991 individuals were served; in FY 1991, 2,690 persons with MR/RC received HCBS including 2,466 who were receiving services on the last day of FY 1991.
- In June 1990, the last year of comparative national data, Minnesota's HCBS program for persons with MR/RC (2,184 recipients) was fourth largest in the U.S., behind California (3,628 recipients), Florida (2,615 recipients) and Pennsylvania (2,221 recipients).
- In June 1990, Minnesota's relative utilization rate of 49.9 HCBS recipients per 100,000 of the state's population was also fourth largest nationally, behind North Dakota (165.1), Utah (69.6) and Colorado (55.9).

Growth in Minnesota's HCSS program since 1985 reflects a controlled substitution of HCBS for earlier reliance and steady growth of ICF-MR residential services.

- **Between 1987 and 1991, Minnesota achieved a 17% decline in ICF-MR residents from 7017 to 5851; ICF-MR residents decreased by 1166 persons, while HCBS recipients increased by 1699 persons.**
- **Between 1987 and 1990 Minnesota's total ICF-MR residential population decreased by 14.0%, as compared with a national decrease of 0.2% and an increase of 0.6% when Minnesota is excluded from the national statistics.**
- **Between 1987 and 1990 Minnesota's total ICF-MR and HCBS recipient populations grew by 5.9%, as compared with a national increase of 13.2%.**

Access to Services

Access to Minnesota's HCBS program is in line with federal requirements and generally meets state standards.

- **HCBS recipients were all confirmed to be Medicaid eligible.**
- **HCBS recipients were all documented to be at risk of ICF-MR placement.**
- **HCBS recipients and community (small) ICF-MR residents were found to have remarkably similar characteristics, presenting strong evidence that HCBS recipients are persons who, in the absence of HCBS services, would have received ICF-MR services. For example, 16.1% of HCBS recipients and 14.9% of community ICF-MR residents have occasional or frequent major seizures or frequent minor seizures; 25.3% of HCBS recipients and 24.6% of community ICF-MR residents need substantial assistance or total care and support in toileting; 55.3% of HCBS recipients and 57.6% of community ICF-MR residents are judged as not being fully capable of independent self-preservation; and 17.2% of HCBS recipients and 18.0% of community ICF-MR residents exhibit moderate or severe aggression toward other persons.**

The period that people had to wait for services once they had been determined to be eligible did not appear to be a serious problem.

- **Families and case managers of current HCBS recipients reported that half received services within 6 months of screening; waits of 2 years or more were extremely rare.**
- **There is within the state no source of complete data on the length of waiting for people not presently served.**
- **Some counties reported deferring screening of persons requesting HCBS when services were not presently or reasonably soon to be available for them. Counties' officials reported deferring screenings to avoid "raising expectations about unavailable services".**

There have been shifts over time in the relative access to HCBS for people being discharged from Regional Treatment centers and other ICFs-MR (called "conversion" enrollees) and people who avoid institutionalization through HCBS (called "diversion" enrollees).

- **In 1985, there were nearly twice as many diversion enrollees as conversion enrollees; between 1986 and 1989, the majority of new enrollees were conversions; in 1990, diversion enrollees made up the**

majority of the HCBS population; in 1991 there were slightly more conversion enrollees than diversion enrollees. Diversion enrollees have increased at a fixed rate of 165 per year.

- Cumulative enrollment patterns have caused a gradual increase in both conversion and diversion enrollees, with June 30, 1992 total enrollments projected to be 1,818 conversions (58%) and 1320 diversions (42%).
- The major factor in the greater access to HCBS by Regional Treatment Center (RTC/ICF) and community ICF-MR residents than persons in the community has been the role of HCBS as the primary program for supporting of Minnesota's overall efforts to depopulate its RTC/ICFs.
- The greater number of conversion than diversion allocations, and the limited access to other community services has created a substantial desire and need for diversion allocations to provide HCBS to persons already in the community but in need of services.

Additional efforts are needed in Minnesota's commitment to equal access to HCBS for eligible persons without regard to race or ethnic background.

- Compared with racial/ethnic distributions reported in the 1990 census, racial/ethnic minorities (Blacks, American Indians, Alaskan Natives, Asians and Hispanics) receiving HCBS were only 55% of the number that would be expected.
- State and County officials acknowledged a need to develop ways to improve program awareness among minority communities, their leaders and their members with disabilities and their families.

Children and youth screened as needing long-term care services have greater likelihood of access to HCBS than adults, because Minnesota has used HCBS relatively extensively to keep children in their homes.

- Minnesota has used HCBS as an important instrument in its commitment to keeping children at home and above all out of RTCs (only 3 young people 17 and younger were left in RTCs in June 1991).
- About 76% of all children and youth (0-17 years) receiving Medicaid long-term care services (RTC, ICF-MR or HCBS) receive HCBS; 29.5% of persons 18-40 years old receiving Medicaid long-term care services receive HCBS; 24.4% of persons 41 years and older receiving Medicaid long-term care services receive HCBS.
- Although children and youth with long-term care needs have greater relative access to HCBS, they make up only 19% of all HCBS recipients.

Minnesota's reliance on county administration and the absence of specific state-policy for county level HCBS allocations to eligible individuals, has led to different approaches to granting access to different groups across counties. Counties demonstrate wide variation in the nature and systematization of their policies and practices in prioritizing eligible persons to receive HCBS.

No families or individuals in the sample reported being denied a desired opportunity to choose among different authorized HCBS or HCBS providers.

- Despite not being denied choice of services or providers authorized for the HCBS program, about 24% of families identified one or more services (not necessarily HCBS services) that their family member needed, but did not receive.

- Unmet needs reported included communication training, integrated recreation, occupational therapy and physical therapy for adults, more appropriate vocational and habilitation services and respite care.

Case managers indicated that there is an inadequate supply of some types of HCBS providers, particularly in some areas.

- About half of the case managers reported an insufficient supply of HCBS providers.
- Shortage of providers was most often reported in rural areas.
- The largest identified need was for providers willing, trained and well-supported to serve persons with special physical/health needs and/or behavior problems.

In summary, access to Minnesota's HCBS program appears equitable and consistent with federal and state regulations. Some pockets of limited accessibility have been pointed out. Some are obviously more easily addressed than others. Many of the problems in accessibility appear related to the high desirability of this program. The number of persons seeking access simply exceeds the number of persons Minnesota has been authorized to serve. Clearly establishing adequate access to this program as "access" is understood by families, case managers and county officials will mean continuing to steadily increase the overall opportunities for enrollment in the program, particularly for persons requiring diversion allocations.

Cost-Effectiveness

Minnesota's expenditures for HCBS have been considerably below those estimated in the original application.

- Minnesota's applications estimated that between FY 1987 and 1991 its total HCBS expenditures would be \$275 million; actual expenditures were \$263 million dollars (more than 4% below projections).
- HCBS expenditures were maintained below approved levels for all years except FY 1989, when actual expenditures exceeded estimates by \$2.4 million.
- In FY 1991, actual HCBS expenditures were only \$64 million, as compared with the projected \$79 million dollars.

In 1991 HCBS per recipient costs were just over half of the ICF-MR per resident costs.

- The average annual cost of HCBS per recipient in 1991 was \$23,702 as compared with an average of \$44,964 per ICF-MR resident
- Between FY 1989 and 1991 the ratio of all Medicaid costs for HCBS recipients to all Medicaid costs for ICF-MR residents decreased from .69 to .58.
- HCBS has indirectly contributed to increasing per person ICF-MR costs in Minnesota by playing such a substantial role in the reduction of RTC residents over whom are spread the fixed costs of operating the institutions.

Persons receiving HCBS had higher costs for Medicaid acute care services (eg., inpatient hospital care, physician services, therapeutic services) than persons in ICFs-MR.

- In 1991 Medicaid acute care costs for HCBS recipients averaged \$12.16 per day as compared with \$8.01 in ICFs-MR; this difference both in terms of percentage and actual dollars has been decreasing

every year since 1988 when acute care services cost an average of \$10.31 per day for HCBS recipients and \$5.18 per day for ICF-MR residents.

- Pan of this difference was attributable to ICF-MR residents (particularly those in larger facilities) having access to acute care services as part of their basic ICF-MR reimbursement rate.

Persons who entered the HCBS program from ICFs-MR (primarily RTCs) had considerably higher average annual costs than people who entered from the community.

- In 1991 HCBS recipients entering from ICFs-MR ("conversion" enrollees) had annual Medicaid costs (HCBS and acute care) of \$31,486 as compared with \$22,963 for HCBS recipients from the community ("diversion" enrollees).
- Two factors in the difference were that about half of the diversion enrollees lived with their families who contributed much of the care and services that had to be purchased for people living outside their natural homes; and that over one-third of the diversion enrollees were children and youth whose major day programs were still educational (not Medicaid funded).

The substantial variability in the program costs of individual HCBS recipients suggested considerable targeting of resources to individual needs and circumstances and considerable use of the flexibility available to counties in the requirement that they work within an *average* reimbursement rate rather than fixed cap on HCBS expenditures.

- A total of 237 HCBS recipients had program costs of less than \$5,000 per year in 1991; these 9% of all HCBS recipients were served with less than 1% of the total HCBS expenditures.
- In 1991 31% of all HCBS recipients had programs that cost less than \$15,000; these programs made up about 10% of all HCBS expenditures.
- In 1991 about 23% of HCBS recipients had programs that cost more than \$40,000, including 2% with programs costing more than \$60,000; programs costing \$40,000 or more made up about 29% of all HCBS expenditures.

Even though the HCBS program has clearly been instrumental in slowing the rate of growth in ICF-MR utilization and expenditures, Minnesota remains one of the heaviest users of and highest spenders for ICF-MR care.

- In 1987 Minnesota ranked first nationally in the number of ICF-MR residents per 100,000 of the state's population (154 as compared with a national average 59); by 1990 Minnesota's ranking had dropped to only to second but its placement rate per 100,000 had decreased substantially (129 as compared with 58 nationally).
- Although Minnesota ranked third nationally in both 1987 and 1990 in ICF-MR expenditures per state resident, Minnesota's per capita ICF-MR expenditures decreased from \$57.70 to \$53.12.
- In 1990 Minnesota ranked fourth nationally in per capita expenditures for combined ICF-MR and HCBS; between 1987 and 1990 as combined expenditures grew 38.2% nationally they grew only 24.9% in Minnesota.
- The Department appears to have developed good internal policies and monitoring mechanisms to assure continued control over the total expenditures for HCBS.

Using relatively conservative assumptions, but excluding costs outside the Medicaid program, between 1987 and 1991 the HCBS program yielded an estimated net savings of \$29.3 million federal and state dollars over expenditures that would have occurred had Minnesota not developed its HCBS program.

- Estimated Medicaid savings to the State of Minnesota due to the HCBS program between 1987 and 1991 were approximately \$14 million state dollars.
- According to Department of Administration, computations Minnesota Supplemental Aid payments to HCBS recipients between 1987 and 1991 were approximately \$20 million dollars.
- It appears that much of the Minnesota Supplemental Aid for HCBS recipients, perhaps as much as 8 million dollars in 1991, funds "supervision" that could be legitimately reimbursed as an HCBS under Minnesota's authorized service category, Supported Living Services.

In summary, the cost-effectiveness of Minnesota's HCBS is well within the definitions established in federal regulations and within the assurances provided in Minnesota's application to provide HCBS. Since the initial application in 1984 and through the most recent four-year period covered by this assessment, the HCBS program has played a central role in removing Minnesota from the position of the nation's most extensive user of ICFs-MR relative to the State's population. Minnesota's HCBS program has been operated with expenditures well below projected levels and with per recipient Medicaid costs that are less than 60% of ICF-MR costs. The state has established policies and monitoring mechanisms which assure continued ability to control HCBS costs.

Quality of Services

HCBS recipients receive a wide range of medical, non-medical, and behavioral and mental health services primarily from typical community clinical practices and caregivers and recipients overwhelmingly rated these services as adequate or better than adequate.

- An estimated 93% of HCBS recipients saw a physician in the previous 6 months, with adults usually seeing family physicians and children seeing pediatricians in typical community clinics.
- Very few HCBS recipients were hospitalized or went to emergency rooms during the previous 6 months.
- An estimated 75% of HCBS recipients received medications, primarily to control seizures and other minor ailments. Only 11% received psychotropic medications, less than half the proportion reported in the 3 largest studies of medications used by community residents with MR/RC.
- An estimated three-quarters of HCBS recipients had seen a dentist at least once in the previous 6 months.
- Children were more likely to receive services from physical therapists, speech/language therapists and occupational therapists than adults, presumably because those services are more readily available in schools than in adult service settings.

Primary care providers indicated that no additional services were needed for an estimated 65% of HCBS recipients.

- The service most commonly reported as needed but not received was speech or communication training (26%), a service not directly authorized as an HCBS.

- Psychological and behavioral analyst services were reported as needed by 17% of HCBS recipients; physical therapy by 10%

Families expressed high levels of satisfaction with HCBS provided to their family members.

- Case managers were rated as excellent by 48% of families, good by 37% and poor by only 2%.
- In-home family support was the only service which was not rated as either excellent or good by at least 80% of the applicable responses.
- Family ratings of quality of services rarely differed by the type of county in which people lived (i.e., Twin Cities urban, outstate urban or rural).
- Typically families reported there were no problems with their members' HCBS, but when problems were reported they most commonly related to the bureaucracy of receiving services and the need for improvements in staffing of services (amount, training, qualifications, and retention/replacement).

Case managers were reported by care providers and families to visit with reasonable frequency and to offer a wide range of assistances to HCBS recipients, families and service providers.

- Careproviders reported an average of 3 visits from case managers in the previous 6 months, with no notable differences by type of placement or type of county.
- When compared with a national sample of case managers of people living in small community residences the case managers of HCBS recipients in Minnesota were more often reported to a) help solve recipient's problems (84% vs. 73%), b) review each aspect of the recipient's program plan (75% vs. 55%), c) make a point of talking directly to the HCBS recipient (87% vs. 74%), d) provide training or advice of meeting the recipients' needs (63% vs. 47%), and e) arrange special training and support when needed (48% vs. 29%). Areas of similarity included a) asking if the individual was having any problems (92% vs. 91%) and b) assisting service providers and families with applications and other paper work (63% vs. 61%).

Case managers expressed considerable satisfaction with the quality of services and the place of residence of their clients.

- About 55% of HCBS recipients had services rated as better than adequate by their case managers; only 2% had services rated as less than adequate.
- About 91% of the HCBS recipients were living in places that were considered to be the most appropriate kind of place at present for their client; by far the HCBS recipients who were most commonly considered not to be living in the most appropriate kind of place (36%) were adults living in their families' homes.

HCBS recipients participated in a wide variety of day activities.

- An estimated 23% of HCBS recipients were engaged in integrated work settings as a primary day activity, 57% participated in segregated settings.
- An estimated 4% of HCBS recipients (5 in the sample) had no day program. All were adults; one was over 65 years and was not interested in a day program. Persons most likely not to have day programs were adults living with their families.

- **Children and youth younger than 22 in education programs made up a third of HCBS recipients; these individuals could have significant cost implications for the HCBS program as they move into adulthood and no longer receive educational services, particularly if vocational opportunities funded by programs other than Medicaid are not available.**

HCBS recipients had a variety of people involved in their lives, but most people in their social networks were family members, people they lived with and service providers.

- **An estimated 85% of HCBS recipients not living at home visited and/or were visited by family members in the previous 6 months; this compares with 69% of community residents in a recent national sample survey. An estimated 40% were visited more than 8 times in the previous 6 months.**
- **An estimated 14% of HCBS recipients were reported to have no friends other than family or people paid to provide services to them.**

HCBS recipients participated in a wide range of community settings.

- **In a one month period HCBS recipients participated an average of 20 times in activities in recreation, leisure and commercial activities in integrated community settings. Participation ranged from 2 times to 65 times. Persons with mild, moderate and severe mental retardation averaged 22 separate involvements, persons with profound mental retardation averaged 12 separate involvements.**
- **During the previous 6 months over 80% of HCBS recipients had at least one time visited a park, a restaurant, a grocery store, a clothing or department store, a medical office and a dental office; at least 60% had visited a corner store or deli, a drug store, a movie theater, a bank, a bowling alley, a library, a playing field, a church and a public beach.**
- **When compared with a national sample of community residents with MR/RC on the use of 6 community resources, Minnesota HCBS recipients were more likely to have gone shopping, gone to a library, gone to a park and gone to a restaurant. There was no difference in the proportion attending movies or church.**
- **Although HCBS recipients participated in a wide variety of activities, an estimated less than 5% participated in these activities with friends who did not themselves have disabilities.**

Careproviders of HCBS recipients, especially adults living in non-family settings, appeared to provide considerable autonomy and opportunity for choice.

- **Corporate foster care settings provided the most autonomy and choice to HCBS recipients. About 80% of recipients living in corporate foster care settings were reported to be able to choose their own bedtime, as compared to half the recipients living in family foster care or in their family's home. Corporate foster care residents were also reported to have considerably greater control over their money, their friends, and their personal activities.**
- **Children and youth living in their own homes appeared to have relatively few opportunities to make choices about activities and schedules.**

HCBS recipients report themselves overwhelmingly to be satisfied with their lives.

- **About 85% of HCBS recipients interviewed indicated they were happy most of the time; 89% report liking where they live.**

- Over 85% of HCBS recipients reported liking their HCBS providers and how they are treated by those providers.

Case managers reported considerably greater preference for the HCBS approach to services as opposed to the ICF-MR approach.

- Case managers generally considered the HCBS to better provide opportunities for more normal, homelike and/or less restrictive living arrangements than ICFs-MR.
- Case managers generally observed that the HCBS approach offers more and better options to support community interaction than ICFs-MR.
- Case managers viewed the HCBS program as providing more flexibility and individualization to respond to individual needs and preferences than ICF-MR.
- A few case managers indicated that HCBS could be considerably preferable to ICF-MR but that because of current regulation and congregate care approaches the actual difference between the approaches was minimal.

Case managers recommended 4 primary ways that Minnesota could improve its HCBS program.

- Paperwork associated with HCBS management and service provision could be reduced, including revision of Rule 42.
- There could be an expansion of diversion allocations and other support services to meet the needs of Minnesotans with MR/RC living in the community.
- There could be increased flexibility in the financing of HCBS services to increase service options and reduce the amount of total program costs going for provider agency administration and fees.
- The State could steadily increase the average reimbursement rate toward the maximum allowable level under federal regulations.

In summary, Minnesota has established comprehensive standards for all HCBS and has established procedures for at least annual review of compliance with those standards and for the correction of observed deficiencies. Overall, the quality of services received by Minnesota's HCBS recipients was rated as generally high by case managers, family members and HCBS recipients themselves. Recipients were active in their communities, had adequate health and dental services and had relatively few services identified as needed but not received. However, HCBS recipients participated in few activities that included typical community members. Concerns about service quality tended to be expressed in terms of the extent to which HCBS services can avoid unnecessary similarities with the highly regulated ICF-MR model which has been dominant in Minnesota and which appears to have affected the regulatory approach taken toward HCBS in the state. There is growing interest in Minnesota, including staff members within DHS, for efforts to rethink Minnesota's traditional, highly regulated licensing and monitoring approaches to "quality assurance." This interest is focusing on more comprehensive and positive approaches to enhancing the quality, including a balance between licensing, monitoring, training, technical assistance, increasing the numbers of providers to increase for choice, providing better supports for families and small providers, and any other promising practices to increase community and social involvements of persons with developmental disabilities.

Recommendations

The State should implement strategies to improve awareness of certain requirements of the HCBS program regarding access and enrollment.

- Evidence is clear that family members are initially informed that HCBS are an option to ICF-MR services and that they may choose ICF-MR services. However, most fail to remember this option after HCBS have been provided for a period of time. Even when access to ICF-MR services is limited to large institutions, periodic reminders should be provided to HCBS recipients and their families of the right of choice they retain.
- "Deferred screenings", that is when people are not screened for their eligibility for HCBS until HCBS allocations are available, should be eliminated; such practices are out of compliance with state regulations, cause underestimation of the need for HCBS and may affect access to HCBS for persons deferred.

The State should work to establish more consistent and systematic policies among counties in the prioritization of individuals to receive HCBS.

The State should work with counties and minority community organizations to improve knowledge about and utilization of HCBS by individuals from racial and ethnic minority groups.

The Department of Human Services should work with counties and with other Departments to improve access to needed HCBS and related services.

- Respite care and employment services are the most frequently identified general services needs, while speech and communication training and psychological or behavioral services are the most frequently identified professional service needs.
- The State should seek to increase the number of individuals and agencies providing services, especially through the recruitment and development of new providers.
- The State should consider alternative requirements for the training, licensing and/or approval of potential providers of non-technical services such as respite care.

The State should carefully examine its use of state-only funds through Minnesota Supplemental Aid (MSA) to fund supervision services that could be legitimately cost-shared with the federal Medicaid program.

- The current practice of funding supervision with MSA appears in conflict with existing state regulations limiting MSA contributions for HCBS recipients to "room and board" which as defined in state regulation does not include supervision.
- Although including the supervision costs currently paid for by MSA under HCBS could increase average HCBS costs by about \$7 or \$8 per day, those costs a) would still be under Minnesota's allowable HCBS expenditures, b) would have no adverse effect on the nature of quality of supervision; and c) would be shared with the federal government at the State's Medicaid matching rate and there by reduced by 53% to the State.

The State should better communicate about and solicit input from counties into the process of requesting and negotiating allocation and distribution of allocations for diversion and conversion enrollees.

- Forums should be expanded to assure that county officials,' case managers' and families' opportunities to receive accurate information about the various constraints and choices in the HCBS application process and ample opportunity to make suggestions on how the State might respond to them.
- The State should communicate balance and sensitivity between the use of HCBS for its goals of deinstitutionalization and the counties' concerns about the growing numbers of unserved individuals and families.

The State should work with counties and providers to prevent overuse of the 3 or 4 person group home to deliver HCBS.

- In many counties the financing and operation of "corporate foster care" homes is very similar to that of ICFs-MR, with the individual's home and services under the control of his/her service provider, potential HCBS benefits of individual control over housing, choice of services and service providers or the potential cost implications of competition and service alternatives are often substantially reduced under this model.
- Choice and personalization of HCBS should be enhanced by efforts to reduce the economic interest that service providers have in the places HCBS recipients live.

The State should develop a concerted effort with counties to increase the pool of potential service providers.

- The State should become directly involved in and provide technical assistance to counties in the recruitment of potential HCBS providers.
- The State should consider a revolving account to assist new providers with loans of "start up" costs until the reimbursement for services cash flow is established.
- The State should develop information and technical assistance programs on getting started as a HCBS provider and dealing with the financial and administrative aspects of a HCBS business.

The State must begin soon to develop the kind of decentralized capacity for providing training, technical assistance, resource development and other quality enhancement activities that is needed to support the rapid growth and increasing dispersal of community service sites.

- At current projections by the end of this decade Minnesota's HCBS program will be its largest Medicaid program for persons with MR/RC. Despite this decentralization of services and dispersal of service recipients to rapidly growing numbers of different sites, the State has done little to improve the access of families and HCBS providers to the kinds of training, technical assistance, and basic supports needed to assure the potential benefit of community living.
- Minnesota has a current and rapidly growing need to decentralize its efforts to assure, enhance and maintain quality in community services through the development of 8-10 localized programs that are integrally involved in service provision in geographically localized areas of the State.
- The move to more geographically localized systems of assistance and support to community providers should be balanced with careful consideration of areas in which regulatory and paper compliance burdens can be replaced by more cooperative and productive commitments to improved quality of services.
- Localized quality enhancement programs should be independent entities governed by a broadly representative Board including key constituencies (e.g., state, county, provider and consumer

representatives) with renewal based on performance. It is critical to their success that the selection and continuation of programs be based on objective assessment of their ability to understand the community needs of HCBS recipients, families, HCBS providers, county case managers and others and to generate the programs and resources that can meet these needs in local communities. A State Support System Project involving Minnesota professionals of the highest levels of knowledge, skill and recognition in assisting others to deal with the many challenges of providing community services should be developed to provide training, technical assistance, resources and support to the area quality enhancement programs.

- Funding for the quality enhancement system should be pegged to a firm standard of commitment to quality management and improvement, minimally 2% of total community Medicaid program expenditures, with the state and federal governments each contributing 1% through the Medicaid cost sharing of administrative expenditures.